CLINICAL LABORATORY SERVICES PAYMENT SYSTEM

*payment***basics**

Clinical laboratory services are tests on specimens taken from the human body (such as blood or urine) and used to help physicians diagnose or assess health. Medicare covers under Part B medically necessary diagnostic and monitoring laboratory services that are ordered by a physician when they are provided in a Medicare-participating lab. With a few exceptions, Medicare does not cover routine screening tests unless directed to by law. Under current law, covered screening tests (with some restrictions) include cholesterol and blood lipid tests, fecal occult blood testing, Pap tests, prostate-specific antigen tests, and diabetes screening tests.

Clinical lab services are furnished by labs located in hospitals and physician offices, as well as by independent labs. Services may also be furnished by labs located in dialysis facilities, nursing facilities, and other institutions, but frequently these services are covered under other Medicare benefits.

Medicare is the largest single purchaser of clinical lab services. Repeated reductions in the payment rates resulted in declining overall program spending for lab services throughout the 1990s. Since 1999, however, Medicare expenditures for lab services have climbed an average of 9 percent per year despite the fact that payments have been updated only once since 1997. In 2004, Medicare payments for clinical lab services totaled $5.8 billion or 2 percent of program spending.

Medicare pays labs directly based on a fee schedule for tests performed in an outpatient setting. To pay for services, the program uses 56 carrier-specific fee schedules established in 1984. Payment rates for each test were set separately in each carrier's geographic market, based on what local labs charged in 1983; since then, the rates have been updated periodically for inflation. National payment limits are set at 74 percent of the median of all carrier fee schedule amounts for each service. In practice, most lab claims are paid at the national limit amounts.

Defining the product Medicare buys

Medicare sets payment rates for more than 1,100 Healthcare Common Procedure Coding System (HCPCS) codes used in billing for laboratory services. Although in theory there is a separate code for each service, in practice a single HCPCS code may identify more than one testing method for a given substance or more than one substance analyzed by a single method. Panel tests, which are tests commonly ordered together, have their own HCPCS codes as well.

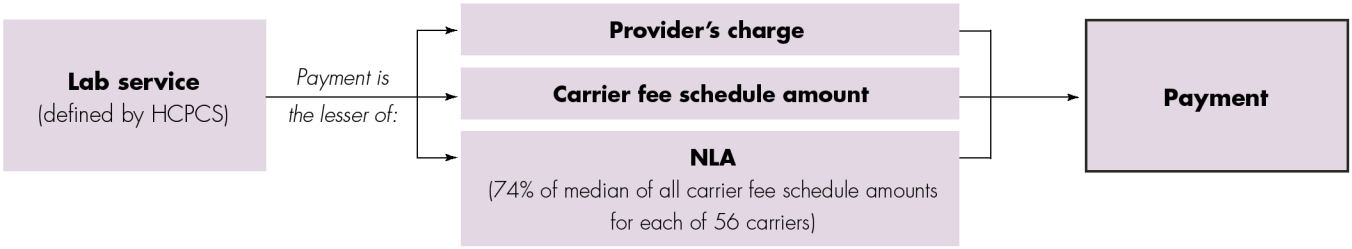
Setting the payment rates

The fee schedule payment rates are the total payment laboratories will receive for their services; there is no beneficiary copayment. Each carrier market has its own fee schedule based upon 1983 charges from the laboratories in that market. Fee schedule amounts may therefore differ from carrier to carrier. Medicare payments were initially set at the 60th percentile of prevailing charges for freestanding laboratories and the 62nd percentile for hospital-based laboratories in each market. In 1987, fees for outpatient services in hospital laboratories, other than those performed in sole community hospitals, were reduced to the 60th percentile of prevailing charges.

Beginning in 1986, the Congress established upper limits on laboratory payment rates, called national limitation amounts (NLAs). NLAs are based on the median of all carrier rates for each test.

MEDPAC
601 New Jersey Ave., NW
Suite 9000
Washington, DC 20001
ph: 202-220-3700
fax: 202-220-3759
www.medpac.gov

Figure 1 Clinical laboratory services payment system



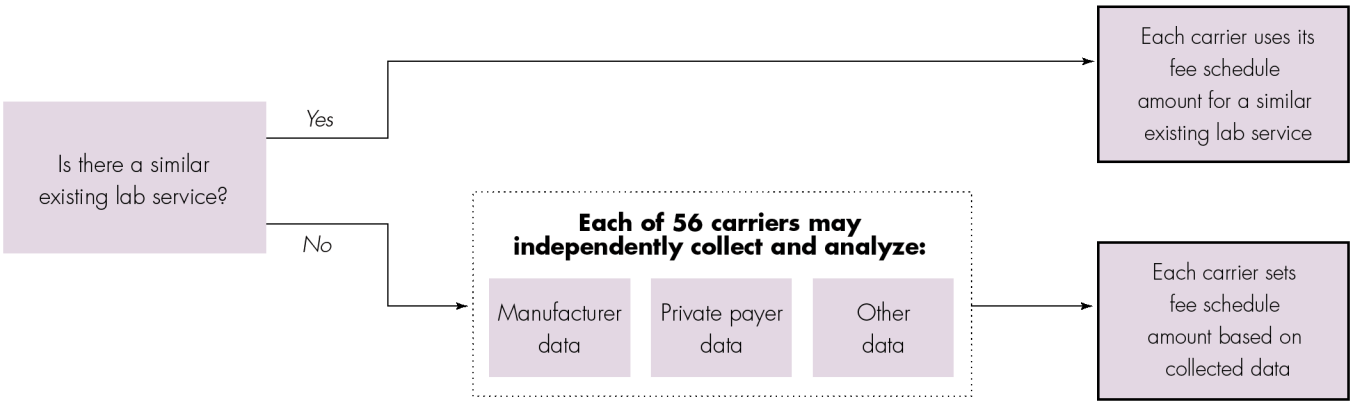
Note: HCPCS (Healthcare Common Procedure Coding System), NLA (national limitation amount). The vast majority of claims are paid at the NLA. Carriers are CMS contractors who are responsible for reviewing and paying providers' Medicare Part B claims.

The NLAs have been repeatedly reduced and currently are set at 74 percent of the median of all local fee schedule amounts for each service. The payment for each service is the lesser of the providers' charge, the carrier's fee schedule amount, or the NLA (Figure 1). In practice, because so many of the carrier payment rates are constrained by the NLAs, most lab services are paid the same national rate.

Initially, lab payments were adjusted for inflation annually using the consumer price index for all urban consumers, but since 1987, the Congress has specified lower update factors or none at all. Payments have been updated only once since 1997.

When newly developed tests are used by laboratories, the Centers for Medicare & Medicaid Services (CMS) assigns payment rates based on their similarity to existing tests (Figure 2). For break-through technologies for which there are no similar existing tests, CMS relies on carriers to independently set rates for the first year of use. Each carrier researches and sets its own payment amount with limited guidance from CMS based on cost data from manufacturers, payment data from other carriers, or other information. Once

Figure 2 Setting carrier fee schedule amounts for a new clinical lab service



Note: Carriers are CMS contractors who are responsible for reviewing and paying providers' Medicare Part B claims.

carriers set their payment rates for a new test, the median rate is identified and the NLA is set at 74 percent of that amount. There is no mechanism for subsequently reviewing payment rates for new tests (or for any tests).

There are some exceptions to the fee schedule for clinical laboratory tests furnished on an outpatient basis. For example, critical access hospitals are paid for laboratory tests on a reasonable cost basis, instead of by the fee schedule. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) introduced an additional exception: hospitals with fewer than 50 beds in qualified rural areas—those with population densities in the lowest quartile of all rural areas—are paid based on reasonable costs for outpatient clinical laboratory tests. This exception will apply to cost reporting periods between July 2004 and July 2006. In addition, the MMA requires the Secretary to conduct a demonstration using competitive bidding for clinical laboratory tests. CMS is currently in the design phase of the demonstration. ■